Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHSIDE PAIN RELIEF CENTER
3033 FANNIN STREET
HOUSTON TEXAS 77004

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TRUCK INSURANCE EXCHANGE

Carrier's Austin Representative
Box Number 14

MFDR Tracking Number
M4-12-3456-01

MFDR Date Received
July 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting your assistance for payment on the above services you have paid for selected services on selected days; however something was paid for 9/13/11. 9/19/11, 9/20/11 and 9/22/11. All of these procedures are accepted and are billable. I'm resubmitting all above DOS along with EOB's to be considered for payment."

Amount in Dispute: $1,017.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor was correctly reimbursed pursuant to the Division's Fee Guideline. Therefore, Requestor is not entitled to additional reimbursement."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2011 through September 22, 2011	97010, A4556, 99204, G0283, 97035, 97150 and 99213	$1,017.21	$152.01

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the procedures for resolving professional medical services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 193 – Original payment decision maintained
   - B15 – Procedure/service is not paid separately

- RG3 – Included in another billed procedure
- RG4 – Service is incidental per Medicare Guidelines
- 59 – Distinct procedural service
- 107 – Denied –qualifying svc not paid or identified
- 168 – No additional allowance recommended
- 197 – Payment adjusted for absence of precert/preauth
- 125 – Denial/reduction due to submission/billing error

Issues

1. Did the requestor the requestor submit documentation to support that the services rendered as billed?
2. Did the requestor submit documentation to support the billing of modifier -59?
3. Did the requestor bill for services in conflict with the NCCI edits?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute."
    - Review of the submitted documentation did not include medical records for disputed dates of service September 9, 2011, September 12, 2011 and September 13, 2011. As a result, Medical Fee Dispute Resolution is unable to determine if the disputed services were rendered as billed. Reimbursement cannot be recommended for dates of service September 9, 2011, September 12, 2011 and September 13, 2011.
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
    - The CPT Manual defines modifier -59 as follows: Modifier -59: "Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries)not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."
3. 28 Texas Administrative Code §134.203 states in pertinent part, "(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." NCCI edits were run to determine if edit conflicts exist for each disputed date of service indicated below. Review of the documentation finds the following;
    - Dispute date of service: September 19, 2011; disputed procedure codes: 97010, G0283, 97035, 97150 and 99213 rendered on September 19, 2011.

      The requestor billed the following CPT codes on September 19, 2011; 99213, 97010-59, G0283-GP-59, 97035-GP-59 and 97150.

      CPT code 97010-59: "Payment for procedure code 97010 is always bundled into payment for other

services not specified and no separate payment is made, per Medicare." The requestor appended modifier -59 and a modifier is not allowed for this procedure. Therefore, reimbursement for CPT code 97010-59 cannot be recommended.

No edit conflicts were identified for CPT codes 99213, G0283, 97035 and 97150, therefore the remaining disputed CPT codes will be reviewed according to the applicable guidelines.

CPT code 99213: The documentation submitted titled "Daily Treatment Notes" does not support the billing of CPT code 99213, as a result reimbursement cannot be recommended for CPT code 99213.

CPT codes G0283, 97150 and 97035: No NCCI edit conflicts were identified for CPT codes G0283, 97150 and 97035; therefore the remaining disputed CPT codes will be reviewed according to the applicable guidelines.

- Dispute date of service: September 20, 2011; disputed procedure codes: 97010, G0283, 97035 and 97150.

  The requestor billed the following CPT codes on September 20, 2011; 97010-59, G0283-GP-59, 97035-59 and 97150.

  CPT code 97010-59: "Payment for procedure code 97010 is always bundled into payment for other services not specified and no separate payment is made, per Medicare." The requestor appended modifier -59 and a modifier is not allowed for this procedure. Therefore, reimbursement for CPT code 97010-59 cannot be recommended.

  CPT codes G0283, 97035 and 97150: No NCCI edit conflicts were identified for CPT codes G0283, 97035 and 97150; therefore the remaining disputed CPT codes will be reviewed according to the applicable guidelines.

- Dispute date of service: September 22, 2011; disputed procedure codes: G0283, 97035, 97150 and 97010.

  The requestor billed the following CPT codes on September 22, 2011; 97010-59, G0283-GP-59, 97035-GP-59 and 97150.

  CPT code 97010-59: "Payment for procedure code 97010 is always bundled into payment for other services not specified and no separate payment is made, per Medicare." The requestor appended modifier -59 and a modifier is not allowed for this procedure. Therefore, reimbursement for CPT code 97010-59 cannot be recommended.

  CPT codes G0283, 97035 and 97150: No NCCI edit conflicts were identified for CPT codes G0283, 97035 and 97150; therefore the remaining disputed CPT codes will be reviewed according to the applicable guidelines.

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications: For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   - Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense.

   - Dates of service: September 19, 2011, September 20, 2011 and September 22, 2011:

     CPT code 97150 (1 unit per date of service) represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.27 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.27324. The practice expense (PE) RVU of 0.28 multiplied by the PE GPCI of 0.992 is 0.27776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.131 is 0.01131. The sum of 0.56231 is multiplied by the Division conversion factor of $54.54 for a MAR of $30.67. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the

first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $30.67. Review of the EOBs provided in the DWC060 request/response supports that the insurance carrier issued payment in the amount of $30.68 for date of service September 19, 2011, therefore no further reimbursement is for September 19, 2011. The requestor is entitled to reimbursement for one unit per date of service for September 20, 2011 and September 22, 2011 at $30.67/date of service minus the over payment of $0.01 for a total recommended reimbursement amount of $61.33.

CPT codes G0283 (1 unit per date of service) represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.18216. The practice expense (PE) RVU of 0.18 multiplied by the PE GPCI of 0.992 is 0.17856. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.131 is 0.01131. The sum of 0.37203 is multiplied by the Division conversion factor of $54.54 for a MAR of $20.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $18.34. The requestor is entitled to reimbursement for one unit per date of service for September 19, 2011, September 20, 2011 and September 22, 2011 at $18.34 x 3 for a total recommended reimbursement amount of $55.02.

CPT code 97035 (1 unit per date of service) represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.21 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.21252. The practice expense (PE) RVU of 0.13 multiplied by the PE GPCI of 0.992 is 0.12896. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.131 is 0.01131. The sum of 0.35279 is multiplied by the Division conversion factor of $54.54 for a MAR of $19.24. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $17.83. Review of the EOBs provided in the DWC060 request/response supports that the insurance carrier issued payment in the amount of $19.25 for date of service September 19, 2011, therefore no further reimbursement is due for date of service September 19, 2011. The requestor is entitled to reimbursement for one unit per date of service for September 20, 2011 and September 22, 2011 at $17.83 x 2 minus the over payment of $1.42 for a total recommended reimbursement amount of $35.66.

5. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of $152.01.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $152.01.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $152.01 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		July 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.